Patient Health and History Form

Date last revised: _____

Child's Full Name: _____
Street Address: _____
City/State/Zip: _____
Birth date: _____ Social Security #: _____

Medical Coverage:
Primary Insurance: _____ ID # _____ Group # _____
Secondary Insurance: _____ ID # _____ Group # _____
Medicaid #: _____
Other: _____
Hospital Record #: _____

Parents/Guardians:
Names: _____
Street Address: _____
City/State/Zip: _____
Home phone: _____ Work phone: _____ Other Work phone: _____
Cell phone: _____ Other Cell phone: _____

In case of emergency and parents cannot be reached, contact:
Name: _____ Relationship: _____ Phone number: _____
Name: _____ Relationship: _____ Phone number: _____
Name: _____ Relationship: _____ Phone number: _____

Diagnosis and Medical History:

_____
_____
_____
_____
_____
_____
_____

Current List of Physicians and Specialists
Name: _____ Specialty: _____ Phone: _____
Address: _____
Name: _____ Specialty: _____ Phone: _____
Address: _____
Name: _____ Specialty: _____ Phone: _____
Address: _____
Name: _____ Specialty: _____ Phone: _____
Address: _____
Name: _____ Specialty: _____ Phone: _____
Address: _____
Name: _____ Specialty: _____ Phone: _____
Address: _____
Name: _____ Specialty: _____ Phone: _____
Address: _____
Name: _____ Specialty: _____ Phone: _____
Address: _____

Surgeries and Extended Illnesses

Date	Surgery/Illness	Reason	Surgeon/Physician	Outcome and Comments

Tests and Treatments

Date	Test/Treatment	Reason	Physician/Professional	Results

Medications

Name of medication	Reason taking med	Dosage	Time given

Special instructions:

_____

_____

Allergies: _____

Immunization dates

DPT/DT	1.	2.	3.	4.	5.
TD	1.	2.	3.	4.	5.
OPV	1.	2.	3.	4.	5.
MMR	1.	2.			
HIB	1.	2.	3.	4.	
Hep B	1.	2.	3.	4.	
Varicella	1.	2.			

Previous reactions to immunizations or other comments:

_____

_____

Seizures

Type	What happens	How often	Response required

Present treatment/medications: _____

Comments: _____

_____

_____

Tube Feeding Schedule

Name of substance	Dosage	Time given

Food allergies:

Oral status:

Other information:

Gastro Status

History:

Interventions needed:

Respiratory Status

History:

Interventions needed:

Communication Skills (verbal/hearing/vision/assistive technology usage)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Mobility Skills/Equipment

_____
_____
_____
Provider: _____ Phone: _____

Home Medical Supplies and Equipment

_____
_____
_____
Provider: _____ Phone: _____

Home Health Care
Provider: _____ Phone: _____
Provider: _____ Phone: _____

School
Name of school: _____ IEP? _____ 504 plan? _____
Address _____
Contact person: _____ Phone: _____
Other information:

_____
_____

Current Therapy Services
Name of provider: _____ Type of service_____
Address _____
Contact person: _____ Phone: _____
Other information:

_____
_____
Name of provider: _____ Type of service_____
Address _____
Contact person: _____ Phone: _____
Other information:

_____
_____